California Department of Health Services

Application for State Approval of
Sickle Cell Education and Counseling Programs
January 1, 2007 - December 31, 2008

Name of Agency or Organization:_____

Address:_____

Website: (if applicable)_____

Satellite Sites (List on Attachment B):

Name of Person Completing Application:_____

Telephone #:_____ FAX #:_____Email_____

1. Services provided which directly relate to sickle cell conditions (Check all that apply):

- ❑ Educational Programs for Community Groups or the General Public
- ❑ Educational Programs for Health Care Providers
- ❑ Educational Programs for Other Professionals and Paraprofessionals
- ❑ Referral for Social and/or Medical Services
- ❑ Development of Health Education Materials
- ❑ Sickle Cell Counseling for follow-up of hemoglobin testing results: List medical programs referring clients to you for sickle cell counseling

  _____

  _____

2. Testing/Screening Services Provided by your Agency? NO ❑ YES ❑
If no, continue to item 4.

3. Methods by which individuals are identified for screening/testing services (Check all that apply)

- ❑ Referrals from Physicians/Health Care Providers
- ❑ Outreach to Persons "At Risk" for Sickle Cell Conditions (Health fairs, Community Organizations)
- ❑ Requests from Parents Referred by Newborn Screening Program
- ❑ Request of Individuals On-site at Agency and/or at Satellite Locations
- ❑ Other (specify)
  _____

4. Laboratory facilities for Community Screening/Testing: List the laboratory(ies) used.

Name of
Laboratory:_____

Address:_____

_____

Laboratory Director:_____

If more than one laboratory is used, attach a list of all laboratories.

5. Counselor Information: List each State Certified Counselor and Date of Certification and/or Recertification (for those certified prior to 1988) Attach copy of counselor certificates.

Name: *Date:*

a._____ _____

b._____ _____

c._____ _____

d._____ _____

6. Counselor Continuing Education: For each certified counselor complete a copy of Attachment A for continuing education hours completed for 2005 –2006. Each certified counselor is required to complete 15 continuing education hours every two years. This requirement can include attendance at state-approved meetings (e.g., NIH's annual sickle cell conference, Sickle Cell Disease Association of America's annual meeting, sickle cell-related hospital grand rounds and approved online classes). **Other educational options must have prior approval by the Genetic Disease Branch.**

7. List all Educational Materials utilized in counseling or educational sessions and target audience. (See Section 6507.2(6) of Regulations)

Name of material *Audience*

a._____

b._____

c._____

d._____

e._____

f._____

g._____

h._____

(Attach additional sheets if needed.)

8. Attach Samples of the Following:

a. Agency brochures describing services

b. If providing testing services please provide a written Consent Form (See Section 6507.5 of Title 17, Code of Regulations). This form should include a statement of voluntary nature of client participation (See Section 6507.4) and confidentiality of client responses. (See Section 6507.2(5))

c. Written description of referral process for medical conditions requiring follow-up including health services, genetic counseling, psychosocial services, etc. Include list of referral agencies.

d. Memorandum of Understanding or Letter of Agreement with any agency serving as satellite counseling site, if applicable.

e. Written agreement with medical consultant to order and interpret laboratory tests used in counseling, if applicable (See Section 6507.2 (4))

The undersigned certifies that the program conducted by the applicant agency will be conducted in compliance with the California Code of Regulations, Title 17, Sections 6500-6508 and further certifies that he/she will notify the Genetic Disease Branch within ten working days of any staff or other changes pertinent to the agency's program approval.

Signature:_____ Date:_____

Name (Print or type):_____Title:_____